HOUSE BILL No. 1226

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-134; IC 12-15-13.5.

Synopsis: Medicaid provider audits. Sets forth requirements for Medicaid recovery audits of Medicaid providers.

Effective: July 1, 2016.

Bacon

January 11, 2016, read first time and referred to Committee on Public Health.

Introduced

Second Regular Session of the 119th General Assembly (2016)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~
Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.
Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2015 Regular Session of the General Assembly.

HOUSE BILL No. 1226

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-7-2-134, AS AMENDED BY P.L.160-2012,
2 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2016]: Sec. 134. "Office" means the following:
4 (1) Except as provided in subdivisions (2) through ~~(4),~~ **(5),** the
5 office of Medicaid policy and planning established by
6 IC 12-8-6.5-1.
7 (2) For purposes of IC 12-10-13, the meaning set forth in
8 IC 12-10-13-4.
9 (3) For purposes of IC 12-15-13, the meaning set forth in
10 IC 12-15-13-0.4.
11 **(4) For purposes of IC 12-15-13.5, the meaning set forth in**
12 **IC 12-15-13.5-1.**
13 ~~(4)~~ **(5)** For purposes of IC 12-17.6, the meaning set forth in
14 IC 12-17.6-1-4.
15 SECTION 2. IC 12-15-13.5 IS ADDED TO THE INDIANA CODE
16 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
17 JULY 1, 2016]:

1 **Chapter 13.5. Medicaid Recovery Audits**
2 **Sec. 1. As used in this chapter, "office" includes the following:**
3 **(1) The office of the secretary of family and social services.**
4 **(2) A managed care organization that has contracted with the**
5 **office of Medicaid policy and planning under this article.**
6 **Sec. 2. (a) The office shall contract with a recovery auditing**
7 **entity to ensure the integrity of the Medicaid program.**
8 **(b) A contract with a recovery auditing entity must include the**
9 **following services:**
10 **(1) Identification of third-party liability.**
11 **(2) Cost recovery of third-party liability through**
12 **post-payment reimbursement.**
13 **(3) Review of claims submitted by providers or other**
14 **individuals furnishing items and services for payment by the**
15 **Medicaid program to determine whether overpayment or**
16 **underpayment occurred.**
17 **(4) Recovery of identified overpayments and payment to**
18 **providers of identified underpayments.**
19 **Sec. 3. (a) The entity that contracts with the office under this**
20 **chapter shall do the following when conducting a recovery audit:**
21 **(1) Review claims not older than two (2) years after the date**
22 **of payment.**
23 **(2) Send a determination letter concluding an audit not later**
24 **than sixty (60) days after the date the provider has provided**
25 **all of the requested materials.**
26 **(3) In any records request, furnish sufficient information for**
27 **the provider to identify the patient, procedure, or location of**
28 **the request.**
29 **(4) Develop and implement within the audit procedure a**
30 **process in which an improper payment identified by an audit**
31 **may be resubmitted as a claims adjustment.**
32 **(5) Use a licensed health care professional from the area of**
33 **health care for which the audit is being conducted to establish**
34 **a relevant audit methodology consistent with established**
35 **practice guidelines, standards of care, and state-issued**
36 **provider handbooks for the profession being audited.**
37 **(6) Provide written notification and explanation of an adverse**
38 **determination that includes the following:**
39 **(A) The reason for the adverse determination.**
40 **(B) The medical criteria for which the adverse**
41 **determination was based.**
42 **(C) An explanation of the provider's appeal rights.**

1 **(D) If applicable, the appropriate procedure for submitting**
2 **a claims adjustment for an overpayment.**
3 **(7) Schedule any onsite audit with advance notice of at least**
4 **ten (10) business days and with a good faith effort to establish**
5 **a mutually agreed upon time and date for the onsite audit.**
6 **The notice of intent to audit under this subdivision is not**
7 **required if the office makes a good faith determination that:**
8 **(A) the health or safety of a recipient of services under the**
9 **Medicaid program is at risk; or**
10 **(B) the provider is engaging in fraud.**
11 **(b) The office shall exclude the following type of claims from a**
12 **recovery audit under this chapter:**
13 **(1) Claims that are currently being audited or have been**
14 **audited by another entity.**
15 **(2) For a medical necessity review, claims for which the**
16 **provider obtained prior authorization for the services and the**
17 **services were performed as authorized.**
18 **(c) Except as provided in subsection (f), the auditing entity may**
19 **not request more than the lesser of the following number of claims**
20 **from a provider being audited:**
21 **(1) Not more than five percent (5%) of the number of claims**
22 **filed by the provider for the specific service being reviewed.**
23 **(2) Two hundred (200) claims.**
24 **(d) The auditing entity may not use extrapolation to determine**
25 **a finding of overpayment or underpayment by a provider unless:**
26 **(1) there is a determination of sustained or high level of**
27 **payment error involving the provider;**
28 **(2) documented educational intervention has failed to correct**
29 **the provider's level of payment error; or**
30 **(3) the value of the claims in aggregate exceeds one hundred**
31 **fifty thousand dollars ($150,000) on an annual basis.**
32 **A finding of overpayment or underpayment may not accrue**
33 **interest during the audit period.**
34 **(e) The audited provider has at least forty-five (45) days to**
35 **respond to and comply with an auditing entity's record request.**
36 **The provider may submit the requested information in an**
37 **electronic format approved by the office.**
38 **(f) If the auditing entity can demonstrate a significant provider**
39 **error rate in relation to the number of claims reviewed, the**
40 **auditing entity may make a request to the office to initiate an**
41 **additional records request concerning the subject under review for**
42 **the purpose of validating the initial findings. The auditing entity**

may not make the request until the time period for the appeals process has expired.

(g) The auditing entity shall provide an initial audit report finding to the audited provider. The audited provider may request in writing an informal consultation with the auditing entity to discuss and attempt to resolve any issues with the audit findings. The auditing entity shall establish an informal consultation process that has been approved by the office. The auditing entity must hold the informal consultation with the auditing provider not later than thirty (30) days after the auditing entity's receipt of the auditing provider's written request for an informal consultation.

(h) A Medicaid provider's clerical error, including a typographical or punctuation error discovered in a record, claim, or document during an audit is not of itself sufficient to constitute intent to violate Medicaid program rules unless proof of intent to violate the Medicaid program is established in relation to the records or documents.

Sec. 4. An audited provider may appeal the audit findings of an auditing entity not later than thirty (30) days after the provider's receipt of the written notification of an adverse determination. An appeal under this section is subject to IC 4-21.5.

Sec. 5. The office may not compensate the auditing entity on a contingency fee basis. The office shall pay the auditing entity the same amount for identifying an underpayment as what the office pays for identifying an overpayment.

Sec. 6. (a) Except as provided in subsection (b), an alleged finding during the audit that a claim was overpaid may not be collected from the provider until the provider:

(1) has completed the entire appeals process as allowed under section 4 of this chapter; or

(2) has accepted the overpayment finding.

(b) The office may collect an overpayment from the provider before the completion of an appeals process by the provider if:

(1) there is a credible allegation that the provider has participated in fraudulent activity;

(2) the auditor has referred the matter back to the office for investigation; and

(3) an investigation has commenced.

Sec. 7. Any savings detected from the performance of a recovery audit under this chapter shall be returned to the Medicaid program.

Sec. 8. The auditing entity, in conjunction with the office, shall

1 **perform educational and training programs annually for providers**
2 **that include the following:**
3 **(1) A summary of the auditing entity's audit findings.**
4 **(2) The most common errors or issues and how a provider can**
5 **avoid these errors and issues.**
6 **(3) Tips for the providers on improving claim submissions.**